THEODORE CARL DREAM CENTER

Marriage Coaching Intake Form

Please fill in the following information. Give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Date: _____ SSN: _____

Your name _____Age____

Spouse's name _____Age____

Children's names _____ Age____

_____ Age____

_____ Age____

_____ Age____

Street Address _____

City _____State_____ Zip Code _____

Phone _____ Cell Phone _____

Email _____ Referral from _____

In case of emergency, whom may we contact? Name: _____

Emergency contact's phone # (other than your own home #) _____

Relationship to client: _____

Counseling History

Have you ever received coaching/counseling for any reason? Yes ___ No ___

When? _____ For What Reason _____

Reason for seeking coaching/counseling now: List goals for coaching if applicable

_____

_____

_____

_____

How long have you been experiencing this difficulty?

_____

Are you presently working with any other Counselor or Psychiatrist? Yes ___ No___

What reason? _____ how long? _____

Counselor / Agency _____

Family History: List any information that may pertain to your present counseling sessions.

_____

_____

_____

Religious History

In what religious faith were you raised if any? _____

Are you seeking Biblical Counseling? _____

Please Check any concerns or issues you have now or in the past:

NOW	PAST
____	____ Alcohol
____	____ Communication skills
____	____ Parenting Issues
____	____ Suicidal thoughts __ suicidal attempt___ suicidal threat___
____	____ Drugs
____	____ Prescription Drugs
____	____ binge eating, excessive dieting or exercise, purging
____	____ shopping
____	____ working too much
____	____ procrastination
____	____ communication
____	____ depression
____	____ anger / rage
____	____ grief
____	____ anxiety
____	____ sexual abuse ___ Physical abuse ___ emotional abuse___ verbal ____
____	____ sex

____ ____ pornography

____ ____ loneliness

____ ____ mood swings

____ ____ low self-esteem

____ ____Self-hatred

____ ____ co – dependency

____ ____ stress

____ ____ fear

____ ____ negative or troubling feelings

____ ____ cutting or self injury

____ ____ addiction

____ ____ Infidelity

Legal Disclaimer Notice for Coaching Services:

I understand and agree the information contained within coaching sessions, classes, conferences or groups, is not a substitute for professional advice such as from a Medical Doctor, Psychiatrist, legal attorney, or licensed therapist of any kind. I also understand the information provided by the Theodore Carl Dream Center (TCDC) or any TCDC employee or sub-contracted consultant does not constitute legal or medical professional advice nor is it intended to constitute such advice.

I fully understand any decisions I make, and the consequences thereof are my own. I agree to services provided by TCDC and agree that I cannot hold TCDC or Jackie Teunessen liable for any actions that I take. I also agree not to hold TCDC or any employees of TCDC, liable for any loss or cost incurred by myself, or any person related or associated with me, as a result of materials or techniques, or coaching, offered by Jackie Teunessen or TCDC Employees or consultants.

I understand the information or techniques used in sessions is intended to be general information with respect to common Life, Health, Relationships and Business issues. Information is offered in good faith, and I do not have to use this information. Nothing in the content materials shall be considered legal, financial, or medical advice.

I understand rates are guaranteed not to change with exception to "specials," unless prior written notice is given.

I understand and agree results are not guaranteed. TCDC and or Jackie Teunessen holds no responsibility for the actions, choices, or decisions taken or made by the client.

Confidentiality

The Theodore Carl Dream Center Organization, Jackie Teunessen and all employees or consultants of TCDC take reasonable steps to keep information of coaching sessions confidential. However, TCDC, Jackie Teunessen nor any of our service providers can ensure or warrant the security of any information you transmit to us over the internet or via text message. Any such transmission is done at your own risk.

Furthermore, TCDC, Jackie Teunessen or any TCDC employee or consultant may disclose any information from coaching sessions as required by applicable law as necessary or advisable to: (a) protect TCDC or TCDC employee rights, safety or property or the rights, safety or property of others from harm; (b) enforce the Terms of TCDC policy and procedure (c) respond to your requests for customer service or other information; (d) comply with legal process or cooperate with law enforcement or governmental requests; or (e) comply with or as permitted by applicable laws and regulations.

Client Responsibility

Client Responsibility: You are responsible for all charges resulting from services provided by T.C.D.C. The primary responsibility for all services is yours. **Your co-payment is always due at the time of service.**

Minors: Clients under 18 years of age will be the responsibility of the custodial parent(s).

No Show Policy: Our policy includes a $20 charge to clients who do not show for their scheduled appointment time or cancel with less than 24 hours' notice.

Insurance: We DO NOT and cannot bill insurance for coaching services. We will only bill insurance if you are under treatment by a licensed program with TCDC or if you are seen by a licensed psychologist. I understand and agree, I am responsible for all appointment charges at the time of my appointment involving all services rendered at TCDC.

Insurance Billing

Insurance Billings for Treatment or Counseling Only: It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information if you are being seen for counseling or treatment. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.

Medicare: We participate with Medicare. We will bill Medicare as your primary insurer for counseling or treatment only. We will also bill your supplemental insurance provider. Medicaid: Please bring your current medical card with you to each appointment.

CLIENT CONSENT TO TREATMENT

I have read and received the Intake Form for Marriage Coaching/Counseling, the Legal Disclaimer Notice, Confidentiality, Client Responsibility, Insurance Billing Notices, and I give my Consent to receive Services by and through the T.C.D.C

Client Signature (Please Sign) Date

_____ _____

Client # 1 Name (please print) Date

_____ _____

Client Signature (Please Sign) Date

_____ _____

Client # 2 Name (please print) Date

_____ _____

Parent / Guardian Signature Date

_____ _____

Coach / Counselor Signature Date

_____ _____